Indiana State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005120 | A. BUILDING: _____ B. WING _____ | 04/07/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VISITING NURSE & HOSPICE HOME | 5910 HOMESTEAD RD FORT WAYNE, IN 46814 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This was the 2015 ISDH Annual Compliance Survey based on the Retail Food Establishment Sanitation Requirements at 410 IAC 7-24.<br><br>Facility Number: 005120<br><br>Survey Dates: 4/7/2015<br><br>QR: JE 4/9/15<br><br>Visiting Nurse & Hospice home was in compliance with 410 IAC 7-24 during their routine annual kitchen sanitation inspection. | S 000 | | |

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE